MAE News – Special Edition

Newsletter from the Office of Monitoring, Audit and Enforcement
Maine Workers' Compensation Board

2015 **Special Edition**

Paul H. Sighinolfi
Executive Director/Chair

Office of Monitoring, Audit and Enforcement

Maine Workers' Compensation Board

27 State House Station

Augusta, Maine 04333

Contacts:

Kimberlee Barriere
Deputy Director
(207) 287-7031

E-mail
Kimberlee.Barriere@Maine.Gov

Anne Poulin
Secretary Associate
(207) 287-7067

E-mail
Anne.Poulin@Maine.Gov

Website:

www.maine.gov/wcb/

New Medical Fee Rule Effective October 1, 2015

There is a new Medical Fee Rule effective October 1, 2015. There are several significant changes that payors must be aware of for dates of service on or after October 1, 2015. Several of these are highlighted below. The complete rule and appendices are available on the Board's website. Any questions or concerns should be directed to Kimberlee Barriere via email at Kimberlee.Barriere@Maine.Gov.

Reimbursement Highlights

- Payors MUST be able to process claims with either ICD-9 or ICD-10 code sets. Any inpatient facility bill received with a date of discharge on or after 10/1/15 billed with the ICD-9 code set can be returned to the provider for proper coding (No NOC is required).
- The employer/insurer must pay the health care provider's usual and customary charge or the maximum allowable payment under this chapter, whichever is less, within 30 days of receipt of a properly coded bill unless the bill or previous bills from the same health care provider have been controverted or denied. Note: a bill is properly coded if it meets all the requirements as outlined in Section 1.06. Properly coded bills may not be returned to the provider because the provider billed with the ICD-9 code set.
- Changes to bills are not allowed. When there is a dispute whether the provision of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids is reasonable and proper under §206 of the Act, the employer/insurer must pay the undisputed amounts, if any, and file a notice of controversy. A copy of the notice of controversy must be sent to the health care provider from whom the bill originated.
- When there is a dispute whether a request for medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids is reasonable and proper under §206 of the Act, the employer/insurer must file a notice of controversy. A copy of the notice of controversy must be sent to the originator of the request.
- Nothing in the rule precludes payment agreements to promote the quality of care and/or the reduction of health care costs, however, please note:
  1. A written payment agreement directly between a health care provider and an employer/insurer supersedes the maximum allowable payment otherwise available under this chapter.
  2. A written payment agreement between a health care provider and an entity other than the employer/insurer seeking to invoke its terms supersedes the maximum allowable payment otherwise available under this chapter only if the employer/insurer was a named beneficiary of the payment agreement at the time the health care provider signed the payment agreement.
  3. An employee retains the right to select health care providers for the treatment of an injury or disease for which compensation is claimed regardless of any such payment agreement.
- Health care providers may charge for completing an initial diagnostic medical report (Form M-1) or other supplemental report. The charge is to be identified by billing CPT® Code 99080. The maximum fee for completing an initial M-1 form or other supplemental report is: Each 10 minutes: $30.00.
- Health care providers may charge for copies of the health care records required to accompany the bill. The charge is to be identified by billing CPT® Code S9981 (units equal total number of pages). The maximum fee for copies is $5 for the first page and 45¢ for each additional page, up to a maximum of $250.00.

MAE News – Special Edition

Newsletter from the Office of Monitoring, Audit and Enforcement Maine Workers' Compensation Board

2015 **Special Edition**

Paul H. Sighinolfi
Executive Director/Chair

Office of Monitoring, Audit and Enforcement

Maine Workers' Compensation Board

27 State House Station

Augusta, Maine 04333

Contacts:

Kimberlee Barriere
Deputy Director
(207) 287-7031

E-mail
Kimberlee.Barriere@Maine.Gov

Anne Poulin
Secretary Associate
(207) 287-7067

E-mail
Anne.Poulin@Maine.Gov

Website:

www.maine.gov/wcb/

Expense Payments Due Within 30 Days

In order to facilitate the payment of employee expenses, the Board has developed a new form: http://www.maine.gov/wcb/forms/WCB-206.pdf. The form is not mandatory. Please note the following regarding payment of employee expenses as outlined in Section 1.10:

1. The employer/insurer must pay the employee's travel-related expenses incurred for treatment (includes travel to the pharmacy) related to the claimed injury in accordance with Board Rules and Regulations Chapter 17.
2. The employer/insurer must pay the employee's travel-related expenses within 30 days of receipt of a request for reimbursement.
3. The employer/insurer must reimburse the employee's out-of-pocket costs for medicines and other non-travel-related expenses within 30 days of a request for reimbursement accompanied by receipts.

New Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule

There is a new DMEPOS fee schedule. Fees for durable medical equipment, prosthetics, orthotics, and supplies are as outlined in Appendix II. Please note that this fee schedule does not apply to supplies on inpatient or outpatient facility bills. Facility charges are covered in sections 3 and 4 of the rule.

Authorization Reminders

- Nothing in the Act or the rules requires the authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206. An employer/insurer is not permitted to require pre-authorization of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids provided pursuant to 39-A M.R.S.A. § 206 as a condition of payment.
- Authorization from the employee for release of medical information by health care providers to the employee or the employee's representative, employer or the employer's representative, or insurer or insurer's representative is not required if the information pertains to treatment of an injury or disease that is claimed to be compensable under this Act regardless of whether the claimed injury or disease is denied by the employer/insurer.
- In the event that the employer/insurer contends that the medical records and information, pre-existing and subsequent to the workplace injury, for which claim is being made are relevant for determination of compensability and disability, it shall obtain from the employee and the employee is obliged to within 14 calendar days execute a limited authorization for focused written medical records only employing the form set forth in Appendix III.
- In the event that the employer/insurer contends that medical or counseling records related to psychological matters, substance abuse, or sexually transmitted disease matters are relevant to issues in the workers' compensation case, it may obtain such specific additional medical and other information as agreed upon among represented parties. In all other cases, specific additional medical and other information shall be requested on written motion to the Hearing Officer showing the need for the information. The Hearing Officer may authorize the release of this information subject to appropriate terms and conditions as to reasonable protection of confidentiality.